Eye Enucleation

Application for Certification

(Please type or print in ink) Date _____

Name:_____
(Last) *(First)* *(Middle/Maiden)*

Home Address:_____ Telephone Number (____)_____

_____
(City) *(County)* *(State)* *(Zip Code)*

Social Security No. ☐☐☐-☐☐-☐☐☐☐ Date of Birth: ☐☐-☐☐-☐☐

Race:_____ Sex: Male ☐ Female ☐

Place of Employment:_____

Title of Position:_____

Business Address:_____ Telephone Number (____)_____

_____
(City) *(County)* *(State)* *(Zip Code)*

Are you currently licensed for the practice of funeral services? No ☐ Yes ☐

If yes, license number (attach a copy of the license) _____

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

My commission expires _____.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

_____ _____
(Notary Public) *(Applicant's Signature)*

Seal

Complete form, enclose fee and mail to:

Mississippi State Department of Health
Professional Licensure - Eye Enucleation
P. O. Box 1700
Jackson, Mississippi 39215-1700

Eye Enucleation

Renewal Application for Certification

(Please type or print in ink) Date _____

Name:_____
(Last) *(First)* *(Middle/Maiden)*

Home Address:_____ Telephone Number (____)_____

_____
(City) *(County)* *(State)* *(Zip Code)*

Social Security No. ☐☐☐-☐☐-☐☐☐☐ Date of Birth: ☐☐-☐☐-☐☐

Race:_____ Sex: Male ☐ Female ☐

Place of Employment:_____

Title of Position:_____

Business Address:_____ Telephone Number (____)_____

_____
(City) *(County)* *(State)* *(Zip Code)*

Are you currently licensed for the practice of funeral services? No ☐ Yes ☐

If yes, license number (attach a copy of the license) _____

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

My commission expires _____.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

_____
(Notary Public)

_____
(Applicant's Signature)

Seal

Complete form, enclose fee and mail to:

Mississippi State Department of Health
Professional Licensure - Eye Enucleation
P. O. Box 1700
Jackson, Mississippi 39215-1700